County: Rural **Date: June 17, 2008**

PEI Project Name: Home Delivered Meals Prevention and Early Intervention Program

Complete one Form No. 3 for each PEI project. Refer to Instructions that follow the form.

1. PEI Key Community Mental Health Needs	**Age Group**			
	Children and Youth	Transition -Age Youth	Adult	Older Adult
Select as many as apply to this PEI project:				
1. Disparities in Access to Mental Health Services	☐	☐	☐	☒
2. Psycho-Social Impact of Trauma	☐	☐	☐	☐
3. At-Risk Children, Youth and Young Adult Populations	☐	☐		
4. Stigma and Discrimination	☐	☐	☐	☒
5. Suicide Risk	☐	☐	☐	☒

2. PEI Priority Population **Note: All PEI projects must address underserved racial/ethnic and cultural populations**	**Age Group**			
	Children and Youth	Transition -Age Youth	Adult	Older Adult
A. Select as many as apply to this PEI project:				
1. Underserved Cultural Populations	☐	☐	☒*	☒
2. Trauma Exposed Individuals	☐	☐	☐	☒
3. Individuals Experiencing Onset of Serious Psychiatric Illness	☐	☐	☒*	☒
4. Children and Youth in Stressed Families	☐	☐		
5. Children and Youth at Risk for School Failure	☐	☐		
6. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement	☐	☐		

* The adults to be served by this PEI program are the family caregivers living with the older adult home delivered meals' clients.

B. Summarize the stakeholder input and data analysis that resulted in the selection of the priority population(s).

MHSA PEI Policy and County Stakeholder Process

As indicated in the Prevention and Early Intervention (PEI) Guidelines, PEI County Plans will address all age groups and a minimum of 51percent of the overall PEI Plan budget must be dedicated to individuals who are between the ages of 0 through 25. Small Counties are excluded from this requirement."

Therefore, to address the Prevention and Early Intervention (PEI) needs of the older adult population in our county, the MHSA Community Services and Supports (CSS) Older Adult Stakeholder Work Group reconvened and formed the PEI Older Adult Work Group. The PEI Older Adult Work Group included additional stakeholder representation to ensure participation by stakeholders of constituencies who are to benefit from PEI. A series of meetings and community forums were held, inviting broad-based stakeholder participation and input. These were open meetings, so additional stakeholders were welcome to join the group at any time. Focus groups were also held at places where PEI stakeholders were already meeting, to broaden the opportunity for stakeholder input.

The stakeholders who participated on the PEI Older Adult Work Group included staff and program participants of the following organizations and constituencies:

1) MHSA CSS-funded programs providing services to older adults, including housing and Older Adult System of Care (OASOC) programs; 2) County Mental Health Older Adult Coordinator; 3) Area Agency on Aging (AAA) staff; 4)Home Delivered and Congregate Meals Programs; 5) Multipurpose Senior Services Program (MSSP); 6) Adult Protective Services (APS); 7) In Home Supportive Services (IHSS); 8) Public Health; 9) Social Services; 10) Alcohol and Other Drug Program (AODP); 11) Hospital social worker; 12) Senior Peer Counselor; 13) Senior Companion; 14) Representatives from the racial, ethnic and culturally diverse communities of our county (Hispanic, Native American Indian/Alaska Native, African American, and Asian/Pacific Islander); 15) Suicide Prevention Services Program/Crisis Line; 16) Older Adult Consumers; 17) Family members of older adult consumers; 18) Patients Rights Advocate; 19) Senior Advocates/Organizations; 20) Mental health professionals specializing in working with older adults; 21) Educational institution with gerontology curriculum (e.g. community college or university.)

Analysis of Stakeholder Input and Relevant Data

The selection of the older adult priority population to be served by the Home Delivered Meals Prevention and Early Intervention Program was informed by review and analysis of the following stakeholder input and data:

- Stakeholder input from the MHSA CSS Community Planning Process and the PEI Older Adult Stakeholder Work Group;
- County MHSA CSS Plan programs serving older adults;
- County demographic data, including data on racially, ethnically, and culturally diverse populations, and Community Health Status Reports;

- County, state and national suicide data on age-adjusted suicide death rate data; suicide attempts/completions rate data; suicide rates by age, gender, race and ethnicity.
- California Strategic Plan for Suicide Prevention: Every Californian is Part of the Solution (Draft)
- Mental health prevalence data and service utilization/penetration data;
- California Department of Aging (CDA) information/data: demographic data, facts about California's elderly, the California State Plan on Aging, and Long Term Care and Aging Services Statistical Fact Sheets and Program Narratives (http://www.aging.ca.gov/);
- County AAA information/data including the AAA Area Plan and the AAA Community Needs Assessment of the older adult population in the County. (California Association of Area Agencies on Aging website links to local Area Agencies on Aging (http://www.c4a.info/LinksHP.html);
- Home Delivered Meals Program data provided by the CDA and the local AAA (www.aging.ca.gov/stats/document/HomeDeliveredMeals08-09.pdf);
- Redwood Coast Seniors, Inc., Fort Bragg, CA, Meals on Wheels Mental Health Outreach Program data. (A model PEI program for older adults age 60 and older who are receiving home delivered meals.);
- Older adult mental health documents regarding Older Adult System of Care Development, evidenced-based practice, best practices, and model programs for older adults:
    - The California Mental Health Directors Older Adult System of Care Committee website (http://www.cmhda.org/committees/Password%20Protected/com_oasoc_docs.html);
    - The California Department of Mental Health, California Mental Health Planning Council The California Mental Health Master Plan, "The Planned System of Care for Older Adults" (http://www.dmh.cahwnet.gov/Mental_Health_Planning_Council/Master_Plan.asp).

The MHSA CSS community planning process identified the following categories of older adults' unmet needs based on stakeholder input: 1) Homelessness; 2) Inability to manage independence, 3) Involuntary care; and 4) Isolation. The following specific service needs were also identified at CSS community forums:

- Culturally competent services (someone to share stories with who shares the client's culture); personal service coordination (e.g., care management); community collaboration with creative care shared by agencies; client and family-driven services that are voluntary; focus on keeping older adults healthy, before problems arise; integrated care that brings services to older adults; persistence and advocacy until diagnosis and medications are correct; transportation; social activities/recreation; counseling, not just medication; get rid of the stigma of mental illness; and healthy food.

The County CSS Plan addressed some of these needs by funding the expansion of its Older Adult System of Care (OASOC) program to provide full service partnership services to new clients diagnosed with a serious and chronic mental illness. This new funding also supported senior peer counseling services and outreach activities to Hispanic and Native American populations who represent the largest minority populations in our county and who are particularly underserved by County Mental Health.

However, the PEI Older Adult Work Group determined that older adults with some of these unmet needs likely would not meet the eligibility criteria for the MHSA CSS full service partnership programs, but could be identified and served through PEI services.

Information Supporting a Home Delivered Meals Prevention and Early Intervention Program for Older Adults

The following data supports targeting for a PEI program older adults who have risk factors for depression and suicide or are experiencing early onset of clinical depression:

- In our county in the year 2000, the population over age 60 was 15,462 (18 percent of the total population, compared to 12% nationwide). Of those 60 years of age and over, 91 percent were white, 4 percent were Hispanic or Latino, 2 percent were Native American, 2 percent were multi-racial, 1 percent were Asian, and 0.3 percent were African American. Of the 11,709 individuals 65 years of age and over, 88 percent had a disability and twenty-five percent of households contained persons 65 years of age or over. In 1999, of those persons below the poverty level, 1,847 (13.7percent) were age 55 years and above.
- Older adults are at a higher risk of committing suicide than any other age group, with white males being particularly vulnerable. According to the National Institute of Mental Health, the highest rate is for white men ages 85 and older: 55 deaths per 100,000 persons, about 5 times the national rate of 10.7 per 100,000.
- Twenty percent of older adults who kill themselves have seen their physician within the past 24 hours, 41 percent within the past week, and 75 percent within the past month, according to the National Institute of Mental Health.
- Our county ranks 7th among California's 58 counties in its age-adjusted suicide rate, with 19.5 suicide-related deaths per 100,000.
- The number of completed suicides versus suicide attempts is highest among the elderly (1 completion to 4 attempts.) Older adults use more lethal means than other age groups to commit suicide. (In our county, there were 9 suicide attempts to 10 completed suicides for persons age 65 or older during 2001 to 2003.)
- Rural areas have a higher incidence of suicide than urban areas.
- Native Americans have a high rate of suicide, 12.4 deaths per 100,000. (Native Americans comprise 4.8 percent of our county population.) The large population of older, isolated Native Americans and Caucasians in our county contributes to statistically high rates of suicide.

- Depression is a strong correlate of suicide in older adults. Consequently, identifying and treating depression is an essential strategy for reducing their risk of suicide.
- Risk factors for depression and suicide in older adults include:
  - Isolation; limited social supports; being a white male age 75 or older; access to firearms; abuse/misuse of alcohol; being recently widowed or divorced; having such medical conditions as heart disease, diabetes, stroke, cancer, and Parkinson's Disease; being a caregiver of a spouse with dementia or other serious medical illness; having a prior suicide attempt or family history of suicide attempts or completed suicides; having experienced a traumatic event; financial stressors.
  - Family caregivers are also at risk for depression due to the stressors of care giving, particularly caregivers of persons with Alzheimer's disease or other dementias.
- Every suicide represents missed opportunities to identify and treat depression, loneliness, isolation and other risk factors that may have contributed to the tragic, preventable event of suicide.
- Inadequate nutrition sets the stage for poor physical and mental health. Many low income homebound older adults do not receive adequate nutrition. Poor nutrition lowers resistance to illness; a vitamin B-12 deficiency also can contribute to depression.
- Home delivered meals programs reach seniors who have multiple risk factors for depression and suicide. The programs can decrease older adults' sense of isolation and loneliness and improve the nutritional status of meal recipients. The Home Delivered Meal Program also targets low income minority populations who would not typically seek out traditional mental health services.
- When a sample of home delivered meals clients served by the Redwood Coast Seniors, Inc. program were screened for depression, 54 percent were identified as being depressed.

3. PEI Project Description: (attach additional pages, if necessary):

Overview of the Home Delivered Meals Prevention and Early Intervention Program

The **Home Delivered Meals Prevention and Early Intervention Program (HDM PEI Program)** will provide mental health prevention and early intervention services to older adults, age 60 and over, who are participants of the Home Delivered Meals Program. These participants are homebound by reason of illness or disability, or otherwise isolated, are typically low income and are at nutritional risk. Because of their physical disability, illness, isolation and nutritional risk, home delivered meals recipients have multiple risk factors for depression and suicide. Some may also have alcohol and substance use/abuse problems, including misuse/abuse of medications, which can increase their risk for depression. Caregivers living with home

delivered meals clients will also receive PEI services because of their risk for depression due to the emotional and physical stressors associated with care giving.

Prevention and Early Intervention (PEI) services with a relatively low intensity and short duration can prevent mental illness from occurring or from becoming severe and disabling. The HDM PEI services will include: 1) Education, 2) Training, 3) Depression screening, 4) Assessment, 5) Brief intervention/counseling, 6) Referral to community resources for assessment and treatment, 7) Care coordination, and 8) Follow-up. The overall goal of these prevention and early intervention services is to prevent the onset of a serious mental illness or reduce the negative outcomes from an untreated mental illness and to prevent the serious and tragic consequence of suicide. A home delivered meals program can reduce the risk of depression and suicide among at-risk older adults, improve their access to and utilization of mental health services, improve their health and nutritional status, and prevent, forestall, or reduce institutionalization.

PEI Priority Population Criteria

The clients of this program would meet the following PEI Priority Population criteria as defined in the PEI Guidelines:

- Individuals Experiencing Onset of Serious Psychiatric Illness: "Those identified by providers, including but not limited to primary health care, as presenting signs of early manifestation of a mental illness including those who are unlikely to seek help from any traditional mental health service."
    - The older adults served by the Home Delivered Meals Program have several risk factors for depression and suicide because of their being homebound by reason of illness or disability, isolation and nutritional risk. These older adults may also have alcohol or other drug problems which frequently co-occur with depression and disability.
    - Older adults, particularly those from ethnically, racially, and culturally diverse populations, are reluctant to seek out traditional mental health services. As a result, they are underserved in both the public and private mental health systems. There are many obstacles and barriers to their utilizing mental health services, among them stigma; lack of knowledge about the signs and symptoms of mental illness, including depression; lack of available, accessible and culturally acceptable mental health services; lack of transportation; high Medicare co-insurance costs for mental health care. The care coordination services of this program will assist the home delivered meals client to connect with such needed mental health resources as a mental health provider or a primary care physician.
- Trauma-Exposed: "Those who are exposed to traumatic events or prolonged traumatic conditions, including *grief, loss and isolation*, including those who are unlikely to seek help from any traditional mental health services."
    - Older adults experience many significant losses in their lifetime, particularly the deaths of a spouse, significant other, family and friends. Due to age they and their spouses/significant others are also at risk for developing serious medical illnesses. These can be traumatic events in their lives, both for the individual experiencing the

illness and the caregiver. Such illness can be medically and emotionally debilitating and isolating. Traumatic experience can place these individuals at risk for the onset of a serious mental illness such as clinical depression and suicide.

- Underserved Cultural Populations: "Those who are unlikely to seek help from any traditional mental health service either because of stigma, lack of knowledge, or other barriers such as being members of ethnically/racially diverse communities or members of lesbian, gay, bisexual, transgender (LGBT) communities, and would benefit from Prevention and Early Intervention programs and interventions."
    - As previously stated, older adults, particularly those from ethnically, racially, and culturally diverse populations, are reluctant to seek out traditional mental health services. Home delivered meals programs emphasize serving individuals in greatest economic or social need, seniors living in rural areas, and seniors who are low-income minorities. Home delivered meals programs constitute an existing service delivery system that already serves underserved, ethnically, racially and culturally diverse populations who would benefit from PEI services, but who do not seek help from traditional mental health providers.

Key Community Needs

This program will address the following Key Community Mental Health Needs:

1. Suicide Risk: This program will increase knowledge of the signs of depression and suicide risk and appropriate actions to prevent suicide for the Home Delivered Meals Program staff, volunteers, clients and their families.
2. Stigma Reduction: This program will reduce the stigma associated with mental illness that may be experienced by older adults and their families. It will provide education and support to reduce stigma and to promote linkage with services and supports.
3. Disparities in Access to Mental Health Services: This program will reach older adults who are underserved in the public mental health system, particularly older adults who are racially, ethnically and culturally diverse, and who live in rural areas.

Levels of Intervention

The Levels of Mental Health Intervention provided by this program include:

1. Prevention/Selective: "Directed at people with some risk often based on their membership in a vulnerable group, whose risk of developing mental illness is significantly higher than average."

    - Older adults in general are in a high risk group for suicide, with the greatest risk being for older adult white men age 75 or older. Depression, a significant risk factor for suicide, is a prevalent mental illness among older adults that can result from a confluence of medical, social and functional conditions.

2. Early Intervention/Indicated: "For people identified as having the greatest risk based on specific symptoms or signs but who lack the criteria for a mental health diagnosis."

    - There is a subset of older adults who have increased risk factors for depression and suicide. Home delivered meals programs serve these high risk older adults who may not reach the "threshold' of a mental health diagnosis, but who may develop a serious mental illness such as depression and be at risk for suicide without prevention and early intervention services.

Components of the Home Delivered Meals Prevention and Early Intervention Program

1) The Home Delivered Nutrition Program (funded by the Older Americans Act with monitoring and oversight by the California Department of Aging and the Area Agency on Aging)

- The Older Americans Act Title III C-2 Home Delivered Nutrition Program provides nutritious meals, nutrition education, and nutrition risk screening to individuals 60 years of age or over who are homebound by reason of illness or disability, or who are otherwise isolated**.** Program goals are targeted to the reduction of social isolation and the promotion of better health through nutrition. Meals meet nutritional standards by incorporating the Dietary Guidelines for Americans and provide a minimum of one-third of the Dietary Reference Intake (DRI).
- Home delivered meals programs provide their clients with a hot meal five days a week delivered by staff or volunteer drivers. Some programs also deliver frozen meals for weekends and holidays. In addition, nutrition education and counseling is provided to improve nutritional status. The program is funded by the federal Older Americans Act, the State General Fund, participant donations, as well as local funds. Home delivered meals services are provided through a network of 33 AAAs and their contracted service providers, and are available in all counties throughout California.
- Home delivered meals providers can reach older adults in isolated geographic areas. They have special access to homebound, isolated older adults who may be difficult to reach by other community service providers who do not provide in-home services. Home delivered meals drivers/volunteers are dedicated, compassionate people who have regular, sometimes daily, contact with clients which results in the development of special relationships over time.
- **Benefits**: Providing meals to homebound eligible individuals is a vital service which in many cases facilitates their ability to remain independent and in their own home. This prevents premature institutionalization and its associated costs. Good nutrition is a major factor in keeping seniors independent and healthy. Homebound seniors who cannot shop for or prepare their own meals, or go out to eat, rely on home delivered meals. The meals allow them to remain living at home with maximum self-sufficiency and independence for as long as possible. The goal is to provide high quality, nutritious, and culturally appropriate home delivered nutrition services to those who are at risk for institutionalization. These nutrition services can maintain recipients' physical, mental and social well being and resiliency, decrease their risk for chronic disease, and increase their independence and quality of life.

- **Eligibility**: Individuals eligible for Title III C-2 nutrition services must be 60 years of age or older and homebound by reason of illness, incapacity, disability, or otherwise isolated. Spouses and caregivers of eligible participants, regardless of age, may receive meals if it is deemed beneficial to the participant. An individual with a disability who resides at home with an older individual may receive a meal if it is deemed in the best interest of the homebound senior. The Older Americans Act emphasizes "serving older individuals in greatest economic or social need, seniors living in rural areas, and seniors who are low-income minorities."

- **Eligibility Assessment**: Each home delivered meals provider develops prioritization criteria to assess the level of need for home delivered nutrition services for each eligible participant based on OAA eligibility requirements. An assessment of eligibility is to be done in the home within two weeks of the start of meal services which includes an assessment of the type of meal appropriate for the participant in their living environment. An older individual eligible for home delivered meals is to be assessed for the need for nutrition-related supportive services and referred as necessary. Re-assessment of need is determined quarterly (either by phone or home visit); however, a home assessment is required at least every other quarter.

- **Staffing**: The Area Agency on Aging has a Registered Dietician on staff (or contracted) to provide oversight, monitoring and support to local home delivered meals program providers. The home delivered meals providers also have on staff a Registered Dietician (RD) who may or may not also function as the program manager. The RD/program manager conducts the day to day management and administrative functions of the program and has the necessary food service management qualifications to perform these duties Staff also includes eligibility workers who provide the eligibility assessments and re-assessments of home delivered meals clients to determine if they meet the eligibility requirements of the program and to assess their nutritional risk. Home delivered meals drivers who deliver the meals are usually volunteers. The home delivered meals drivers' primary responsibility is to assure that each participant on their route receives a daily meal. They also have a responsibility to provide a "Daily Status Check" to assure that participants are all right on a daily basis. The drivers see home delivered meals recipients on a regular basis over time which enables them to notice changes in the clients and their caregivers that might not be noticed by others with whom the clients and caregivers have sporadic contact.

  Older Americans Act regulations specify that "there shall be a sufficient number of qualified staff with the appropriate education and experience to carry out the requirements of the Program." The total number of staff is based on the level of services provided and the size of the service area. Volunteers are recruited and used in any phase of program operations where qualified.

- **Training**: Home delivered meals program RDs, program staff and volunteers receive training specific to their assigned responsibilities such as training in food safety, first aid, accident prevention, what to do in an emergency or if the client does not answer the door, eligibility and nutritional risk assessment/re-assessment, home assessment, and daily status checks. All home delivered meals drivers are trained to provide "Daily Status Checks" to determine if there has been a change in the clients' physical or emotional status and their home environment and to report any changes to their direct

supervisor. A yearly written plan for staff training is to be developed, with a minimum of four hours of training provided annually for all staff.

2) Prevention and Early Intervention Services (PEI staff and services are to be funded by Mental Health Services Act PEI funds)

- **Staffing:** A masters-level licensed mental health clinician with a specialization in geriatric mental health would be added to the Home Delivered Meals Program staff to oversee and deliver PEI services. Senior peer counselors and peer support counselors may also be hired if these programs and services are not available in the Home Delivered Meals Program service area. These supportive counseling services can reduce the risk of depression by reducing social isolation and loneliness and would complement the brief intervention services provided by the mental health clinician.

  The number of mental health clinicians, senior peer counselors and peer support counselors needed would depend on several factors: the number of home delivered meals program participants, the size of the service area, and the number of clients and caregivers who score positively for depression, require a mental health assessment, brief intervention/short term counseling, referral, care coordination, and follow-up services.

  The licensed mental health clinician would be responsible for the following: 1) Clinical oversight of the Program's PEI services including supervision of the drivers, senior peer counselors and peer support counselors regarding mental health service interventions with clients and caregivers; 2) Education and training of staff regarding PEI including training on recognizing the signs and symptoms of depression, suicide risk, and co-occurring alcohol abuse/medication misuse; 3) Review and interpretation of all depression screening results; 4) Mental health assessment and education of clients and caregivers who score positively for depression or have a change in their emotional and mental status as identified by the eligibility worker, driver and other staff/volunteers; 5) Brief intervention/short term counseling services for the clients and caregivers who exhibit signs and symptoms of depression; 6) Referral of clients and caregivers to community resources such as mental health service providers (public or private) or to primary care physicians, particularly if the client and caregiver may require medication management of the depression; 7) Care coordination to promote referral to and linkage with community services and supports; and 8) Follow-up to ensure that the client and the caregiver receives the needed services and to monitor outcomes of assessment and treatment interventions.

  Home delivered meals drivers/volunteers will continue to play an important role with home delivered meals clients and their caregivers due to their regular contact with the clients and the relationship that develops over time. Drivers/volunteers are recruited who have the following skills and qualifications: compassion, reliability, interest in working with homebound older adults and their caregivers, interpersonal skills that will foster the development of supportive relationships with home delivered meals clients and their caregivers, the ability with training to observe changes in the emotional, mental and physical state of the clients and caregivers and to communicate these changes to the mental health clinician. Using volunteer drivers in this capacity is supported by the success of the "Gatekeeper Program Model". This is an evidenced-based practice of targeted outreach to vulnerable older adults by training non-

traditional referral sources to identify and refer older adults living in the community who are at risk for serious mental health problems and substance abuse.

The RD/program manager, eligibility workers, drivers, mental health clinician, and other staff such as senior peer counselors and peer support counselors would function as a "treatment team" and have team meetings to ensure collaboration and coordination of PEI services to the home delivered meals clients and caregivers.

- **Training**: The following training specific to PEI will be provided by the mental health clinician to the Home Delivered Meals PEI Program staff and volunteers: 1) recognizing the signs and symptoms of depression, alcohol abuse/medication misuse, the warning signs of suicide, and evidence of neglect or abuse; 2) knowing what to communicate and when to the mental health clinician if changes in the clients' and caregivers' mental/emotional health and home environment is noticed; 3) understanding the issues of cultural and ethnic diversity in relation to mental health issues, to promote cultural sensitivity and competence in working with diverse clients. Training will promote the ability of the staff, particularly the eligibility workers and drivers, to identify clients and caregivers who need an assessment by the mental health clinician.

- **Education**: Home delivered meals clients would be given nutrition, health and mental health information during their initial eligibility assessment. Mental health information would be provided particularly about depression and its effective treatment because these clients are at risk for depression which may not be recognized by the clients themselves or their family members/caregivers. Also during the initial eligibility assessment, the clients and caregivers will be asked to complete a confidential, self-administered depression screening tool within the first two weeks of the initiation of home delivered meals and return it to the driver in a sealed envelope for review by the program's licensed mental health clinician. The purpose and importance of the depression screening as well as the confidentiality of its results will be explained to the clients and caregivers. For clients and caregivers who screen positively for depression, the mental health clinician will provide a mental health assessment, review the results with the clients and caregivers, and recommend a plan of treatment that may include a combination of counseling, medication and self-care interventions.

  Education is important in helping clients and caregivers overcome barriers to seeking depression care due to stigma. The message that will be conveyed by the mental health clinician is that depression is not a normal part of aging, and that depression is a treatable illness. Providing this information and talking about depression as an illness to both the client and family caregiver begins a process of de-stigmatizing mental illness.

- **Depression Screening**: Screening is used to identify individuals who may be depressed and who may also have a co-occurring alcohol problem. Screening results provide an objective measure for monitoring the existence, severity and change in depression/depressive symptoms and their response to treatment interventions over time. Screening results are used to guide "next steps" in the assessment and treatment process. A screening instrument should be used which is reliable (provides consistent results across people and raters), valid (measures what it is proposed to measure), standardized (can be used for comparative purposes) and sensitive (measures change over time.) Some screening tools are self-administered; others require administration by a trained professional. However, all screening results should be

reviewed and interpreted by a licensed mental health clinician or healthcare provider who would then inform the client and caregiver about the results and make recommendations for next steps.

Examples of self-administered depression screening tools for the geriatric population that could be used in the HDM PEI Program are the Geriatric Depression Scale (short form) and the Patient Health Questionnaire PHQ-9. Alcohol screening instruments used with older adults include the Michigan Alcohol Screening Test (short MAST-G) and the Complaint-Annoyed-Guilty-Eye-Opener (CAGE).

All home delivered meals clients will be asked to complete a confidential self-administered depression screening tool validated for use in the older adult population. This screening will be incorporated into the Home Delivered Meals Program's initial and annual home delivered meals eligibility assessment/reassessment. The screening results will be reviewed by a licensed mental health clinician. If the screening results indicate the possibility of depression, the mental health clinician will provide an in-home mental health assessment to determine next steps, i.e., what referrals and treatment interventions are needed. Depression screening will be completed at least quarterly for clients and caregivers who are receiving treatment interventions to monitor progress and outcomes of referrals and treatment interventions.

- **Assessment**: Depression screening is used to determine if an individual is depressed and to what degree. However, a mental health assessment is necessary to confirm the screening results. This assessment would be provided by the licensed mental health clinician and the results would guide the most appropriate next steps, i.e., provide brief intervention/short-term counseling services, and/or refer to a mental health program/provider or primary care physician for further assessment and treatment.
- **Brief Intervention** (up to one-year): The licensed mental health clinician of the HDM PEI Program would be trained to provide evidenced-based, short term counseling interventions for the treatment of depression such as "Problem Solving Therapy" (which is used in the IMPACT Program, an integrated model of collaborative care in primary care), and "Behavioral Activation Therapy" (which is used in the Healthy IDEAS Program, Identifying Depression, Empowering Activities for Seniors.) The Healthy IDEAS Program is designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations through existing community-based case management services. Behavioral activation therapy improves mood by increasing the frequency of behaviors that lead to positive outcomes, doing activities that "feel good" or are pleasurable or reduce stress. Behavioral Activation Therapy may involve a task, something social or an activity. Refer to the following websites for more information about IMPACT and Problem Solving Therapy (www.impact-uw.org) and the Healthy IDEAS Program (www.careforelders.org/healthyideas).
- **Care coordination:** Care coordination is a process of client education and support, referral, advocacy and follow-up. Care coordination services promote referral to and linkage with community resources that address identified needs and can enhance and sustain an individual's independence at home, reducing the risk of premature or inappropriate nursing home placement. The HDM PEI Program's mental health clinician will provide care coordination, referral and follow-up services.

- **Referral**: The mental health clinician makes referrals based upon the assessment results and treatment needs of the clients and caregivers. The clinician provides an important link between the client/caregiver and treatment service providers, particularly if medication management is required. Referrals may be made to county mental health, private mental health providers, primary care physicians/clinics, community-based aging and long term care services such as adult day health care, alcohol and drug programs, family caregiver support programs, and other community resources.

  Primary care physicians are a particularly important resource for the treatment of depression, as more than 70 percent of antidepressant medication is prescribed by the family doctor. Older adults in particular are more willing to visit primary care physicians than mental health providers due to issues of stigma. However, data indicates that primary care physicians may not always recognize depression and suicide risk among their elderly patients. According to NIMH, many older adults who commit suicide have visited their primary care physician very close to the time of the suicide: 20 percent on the same day, 40 percent within one week, and 70 percent within one month of the suicide.

  The HDM PEI Program's mental health clinician performs a critical liaison role with the primary care physician, similar to the role that the "depression care manager" has in the IMPACT Depression Care Model. The mental health clinician refers and coordinates depression care in collaboration with the primary care physician, including the provision of brief intervention counseling services such as Problem Solving Treatment and Behavioral Activation Therapy as utilized in the Healthy IDEAS Program model. The mental health clinician functions as a "partner in care" with the primary care physician by providing feedback to the primary care physician about a client's treatment response (with the client's authorization to do so.)

- **Follow-up**: Follow-up services provided by the mental health clinician are important to ensure that the client or caregiver connects with the recommended community resources and is receiving needed assessment and treatment services. Follow-up is also essential to determine the outcome of referral and treatment interventions.

Home Delivered Meals Prevention and Early Intervention Program: Integrating Evidenced-based and Promising Practice Program Models

The Home Delivered Meals Prevention and Early Intervention Program (HDM PEI) was designed based on the following evidenced-based and promising practice model programs: 1) Meals on Wheels Mental Health Outreach Program of Redwood Coast Seniors, Inc., 2) Problem Solving Treatment (utilized in the IMPACT Depression Care Model Program), 3) Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) and Behavioral Activation Therapy utilized in the Healthy IDEAS model program, and 4) The Gatekeeper Program Model.

1) The **Meals on Wheels (MOW) Mental Health Outreach Program** is a promising practice model program that has operated successfully for five years in Mendocino County by Redwood Coast Seniors, Inc. The goals of the MOW Mental Health Outreach Program include: 1) Increase MOW participation; 2) Develop MOW and outreach staff skills in depression screening; 3) Generate appropriate mental health referrals with follow-up to determine if linkage with community resources

occurred and to evaluate the outcome; 3) Increase access to mental health services for isolated seniors; 4) Decrease isolation and loneliness; 5) Prevent suicide among older adults.

The MOW Mental Health Outreach Program has the following outcome data to support its value and success in achieving objectives which are consistent with the MHSA PEI Community Needs, Priority Populations and Principles:

- This model program serves clients who are racially, ethnically and culturally diverse (Hispanic, Native American, and Asian/Pacific Islander). It also serves both males and females (33 percent males, 67 percent females) with a wide range of ages. The male clients in this program ranged in age from 60-104, and females, from age 60-99. For example, from July 1, 2007 through March 26, 2008, 147 clients received home delivered meals services. Of the males receiving services, 6 percent were age 60-64, 16 percent were age 65-69, 10 percent were age 70-74, 18 percent were age 75-79, 12 percent were age 80-84; 24 percent were age 85-89, 8 percent were age 90-94, 4 percent were age 95-99, and 2 percent were age 100-104. Of the females receiving services, 5 percent were age 60-64, 7 percent were age 65-69, 7 percent were age 70-74, 10 percent were age 75-79, 23 percent were age 80-84, 23 percent were age 85-89, and 15 percent were age 90-94.

- Forty-five percent (81 of 180) of the clients screened with the geriatric depression screening tool scored in the moderate to severe range of clinical depression, more than twice the national average of 20 percent for the general population over age 60. Sixty-six percent of these depressed clients (53) followed up and received recommended mental health treatment during the first six months of fiscal year 07/08.
- Sixty-two percent of the home delivered meals recipients showed improvement in their nutritional risk profile during the first six months of fiscal year 07/08. The average nutritional risk of the male clients was higher than that of the females.
- Ninety-three percent of the clients reported feeling less lonely since receiving home delivered meals, and 98 percent reported they would feel comfortable talking with their meals on wheels driver about personal matters. This reduction in loneliness is a reflection of the significance of the relationship developed between the home delivered meals participant and the driver.
- Fifty four percent of the clients discontinued the service as a result of improved health status. Only six discontinued as a result of admission to a nursing facility. The human and emotional value of being able to remain in one's home with care and dignity is an important objective for this program.

The following service elements of the MOW Mental Health Outreach Program are incorporated into the Home Delivered Meals Prevention and Early Intervention Program: 1) Depression screening to home delivered meals clients who are at risk for depression and suicide; 2) Training of staff and home delivered meals drivers/volunteers about older adult mental health issues and effective treatments, including recognizing signs and symptoms of depression, suicide risk, co-occurring alcohol abuse, elder abuse and neglect; 3) Provision of cultural education and sensitivity training for work with ethnically and

culturally diverse home delivered meals clients and caregivers; 4) Referral of clients who screen positively for depression to mental health and primary care service providers for assessment and treatment services.

The following staffing and service elements are not provided in the MOW Mental Health Outreach Program but have been added to the proposed Home Delivered Meals Prevention and Early Intervention Program: 1) A licensed mental health clinician with geriatric mental health experience to oversee the PEI services of the program including depression screening, mental health assessment, brief intervention/counseling services, ongoing care coordination, referral and follow-up; 2) Hiring of senior peer counselors and peer support counselors if these programs are not available in the Home Delivered Meals Program service area; 3) Provision of brief intervention counseling services to include Problem Solving Treatment and Behavioral Activation Therapy; 4) Ongoing care coordination and follow-up for clients and caregivers who are referred for assessment and treatment services.

2) **Problem Solving Treatment and the IMPACT Depression Care Model Program** (www.impact-uw.org)

The IMPACT model of depression care is an evidenced-based practice which co-locates a depression care manager (a nurse, social worker, or psychologist) in a primary care clinic. The depression care manager 1) works closely with the primary care physician providing patient education and support of antidepressant medications prescribed in primary care, 2) coaches patients in pleasant events scheduling and behavioral activation treatment, 3) offers a brief (6-8 session) course of counseling such as Problem Solving Treatment (PST), 4) monitors depressive symptoms and response to medication and/or PST; 5) works closely with the primary care provider and a consulting psychiatrist to revise the treatment plan when patients are not improving.

Problem Solving Treatment (PST) is an evidenced-based short-term counseling intervention used in the IMPACT Model Program to treat late life depression using 4-8 treatment sessions, meeting every other week, and delivered in non-mental health settings. PST increases a patient's understanding about the link between current symptoms and current problems in living, increases a patient's ability to clearly define problems and set concrete and realistic goals, and teaches a patient a specific structured problem-solving procedure.

The HDM PEI Program will utilize Problem Solving Treatment as the brief treatment intervention for home delivered meals clients who are identified through depression screening as having an early onset of depression.

3) **Healthy IDEAS Model (Identifying Depression, Empowering Activities for Seniors) and Behavioral Activation Therapy** (www.healthyagingprograms.org)

The Healthy IDEAS Program Model (Identifying Depression, Empowering Activities for Seniors) is an evidenced based program to detect and address depressive symptoms in older adults with chronic health conditions and functional limitations. Healthy IDEAS targets older adults, including older caregivers, living in the community and utilizes community-based case managers or caregiver specialists to: screen clients for depressive symptoms using a standardized depression scale, educate clients about depression treatment and self-care, link clients to healthcare and mental health professionals, help clients engage in "behavioral activation", coach and support clients as they pursue personal, meaningful goals. The Healthy

IDEAS Program is intended to become embedded in an organization's existing case management practice or caregiver support program.

The HDM PEI Program will utilize all service elements of the Healthy IDEAS Program Model, including "Behavioral Activation Therapy." Behavioral Activation techniques are also used in Problem Solving Treatment with the IMPACT Program Model.

4) **The Gatekeeper Program** (www.samhsa.gov/OlderAdultsTAC/EBPDepressionAnxietysectionFinal.doc)

The Gatekeeper Program was developed to train non-traditional referral sources to identify and refer older adults living in the community who are at risk for serious mental health and substance abuse problems. Examples of gatekeepers are employees of local businesses and community organizations who have contact with older adults (e.g., letter carriers, police officers, bank tellers, landlords, meter readers, and others.) The "gatekeeper" model has been compared with traditional referral sources (e.g., medical providers, family members, informal caregivers, or other concerned persons) to determine its efficacy in identifying vulnerable older adults in need of services. Studies of the Gatekeeper Program have found differences in individual characteristics between individuals referred by gatekeepers and those referred by medical or other traditional sources. Older adults (age 60+) referred by gatekeepers were significantly more likely to live alone, were more often widowed or divorced, and were significantly more likely to be affected by economic and social isolation. These findings suggest that the gatekeeper model may uniquely provide outreach to individuals who are less likely to access services through conventional referral approaches.

The HDM PEI Program will train home delivered meals drivers and eligibility workers as "gatekeepers," to enable them to identify and refer older adults and their caregivers in the home delivered meals program who are at risk for serious mental health and substance abuse problems.

4. Programs

Program Title	Proposed number of individuals or families through PEI expansion to be served through June 2009 by type		Number of months in operation through June 2009
	Prevention	Early Intervention	
Home Delivered Meals Prevention and Early Intervention Program	Individuals: 361 Families: 133	Individuals: 78 Families: 45	9 months (estimate begin program implementation in September 2008
	Individuals: Families:	Individuals: Families:	
	Individuals: Families:	Individuals: Families:	
	Individuals: Families:	Individuals: Families:	
TOTAL PEI PROJECT ESTIMATED *UNDUPLICATED* COUNT OF INDIVIDUALS TO BE SERVED*	**Individuals: 361 Families: 133****	**Individuals: 78 Families: 45*****	

***The total unduplicated count of individuals and family caregivers to receive services is 494 (361 home delivered meals' clients and 133 family members/caregivers.) Of the 361 home delivered meals' clients, 120 are male and 241 are female.**
****Family caregivers estimated to receive Prevention and Early Intervention Services live in the home with the home delivered meals clients.**
*****Studies indicate that an estimated 50% of family caregivers suffer from depression.**

5. Linkages to County Mental Health and Providers of Other Needed Services

The primary objectives of this program are 1) to identify individuals at the early stage of onset of a serious mental illness through depression screening and provide education, assessment, brief intervention treatment, referral to needed mental health and healthcare, care coordination, and follow-up services as previously described to prevent the illness from becoming severe and disabling, and 2) to prevent the onset of a mental illness by reducing associated risk factors such as social isolation, loneliness and poor nutrition for home delivered meals clients, and by reducing the stressors associated with care giving for the family caregivers such as providing respite and counseling services.

The Home Delivered Meals PEI Program mental health clinician will be responsible for recommending and making the referrals to community resources to address the mental health as well as other needs of the home delivered clients and caregivers. These community resources will include county mental health services, private mental health providers, primary care physicians, community-based aging and long term care services, alcohol and drug programs and other community resources depending upon the identified needs. The care coordination component of this program will promote referral to and linkage with these programs, providers and community resources. Care coordination will include follow-up to ensure that the needed services are provided and that the desired outcomes are achieved.

6. Collaboration and System Enhancements

The Home Delivered Meals PEI Program will build capacity within the existing Home Delivered Meals Program network to provide mental health prevention and early intervention services for homebound home delivered meals clients and their caregivers. Providing mental health services in the home will enhance the ability of these clients to access and receive mental health services that they might not access otherwise.

Older adults and their caregivers who receive services in the Home Delivered Meals Program (as well as other AAA programs) have multidisciplinary needs. The Home Delivered Meals PEI service components will enhance the capacity of the program to develop and strengthen collaborative relationships with the mental health system (public and private), the medical system (public and private), alcohol and drug programs, and other service providers to promote a multidisciplinary approach to care for at risk older adults and their caregivers receiving home delivered meals.

These service delivery systems need to collaborate and share resources whenever possible on behalf of the clients they serve. The challenge is in coordinating and collaborating to ensure effectiveness and efficiency in the delivery of these services. Care coordination and collaboration is an essential service component for any program providing services to older adults to address their complex needs.

The Home Delivered Meals PEI Program will leverage the resources of the Area Agency on Aging service delivery system and will reach clients who are ethnically and culturally diverse in rural, isolated areas and who are traditionally underserved

in the public mental health system. The infrastructure for the Home Delivered Meals Program already is in place, including mechanisms for data collection and reporting. Some additional data will need to be collected related to the PEI service components, but this information can be collected and summarized by the individual home delivered meals service providers.

MHSA PEI funds will be used to support mental health training for home delivered meals program staff and volunteers. When this training is provided, AAA staff and subcontractor organizations should also be able to attend so that this training can enhance the ability and capacity of the staff in the broader AAA community-based service delivery system to identify clients who have unmet mental health needs in their respective programs.

AAA programs perform an important "gatekeeper" role for identifying older adults, adults with disabilities and their caregivers who need mental health services. It is important to build the AAA service system's capacity to do so.

7. Intended Outcomes (Refer to Completed PEI Guideline Form 7 for Program Evaluation Information)

PEI Program Client Outcomes

1. No suicide attempts or completions.
2. Reduction or elimination of depression or depressive symptoms for clients identified as being depressed/having depressive symptoms.
3. Reduction or elimination of feelings of isolation and loneliness.
4. Increase in feelings of support.
5. Improvement of nutritional status for clients/caregivers who are identified as being depressed.
6. Successful referral to and linkage with treatment services for clients/family caregivers identified as being depressed.
7. Reduction or elimination of stigma regarding depression/mental health issues and utilizing mental health services.
8. Satisfaction with mental health prevention and brief intervention services by clients/caregivers, including whether services were provided with ethnic/cultural sensitivity and competency.

PEI Program/System Level Outcomes

1. All clients and family caregivers will receive information about mental health issues including depression and suicide along with information about health and wellness.
2. All clients/family caregivers will be screened for depression at least once each year.
3. All clients/family caregivers who screen positively for depression will receive ongoing depression screening.
4. Number of Native American Indian, Hispanic, African American and Asian/Pacific Islander clients served will increase by 10 percent.
5. Number of male clients will increase by 5%.
6. All program staff, drivers and volunteers will receive mental health training, including information about the mental health and service needs of racially, ethnically and culturally diverse populations.
7. Drivers and volunteers will feel prepared to perform their "mental health observation and intervention" services.
8. Cross referrals between the home delivered meals program and mental health will increase.
9. Cross referrals between the home delivered meals program and primary care physicians/clinics will increase.

8. Coordination with Other MHSA Components

The MHSA CSS funded programs serving older adults are an important resource for the Home Delivered Meals PEI Program, particularly if home delivered meals clients are identified as having a serious mental illness and meet the eligibility criteria for a full service partnership. These MHSA Full Service Partnership Programs are particularly important for clients who are eligible for MediCal as well as dual eligible for Medicare and MediCal.

It is also possible that clients receiving services within the County Mental Health CSS Programs may need home delivered meals and other AAA-funded services so that their clients can remain living as independently as possible in the community. Therefore, mental health and aging programs need to have a collaborative working relationship to best utilize each other's resources appropriately and effectively. It is anticipated that this PEI program will increase the number of cross referrals between the home delivered meals program and county mental health programs that serve older adults.

The MHSA Workforce Education and Training phase of funding is also relevant to the home delivered meals program and to all AAA program staff and subcontractor providers, including volunteers. The staff and volunteers of the community-based aging and long term care service delivery system work with clients with mental health needs. Training these staff and volunteers to identify the mental health needs of their clients and to provide brief interventions would leverage the resources of the AAA

system to provide PEI services at sites/programs where older adults receive other services. These would include: senior centers, congregate meal sites, Adult Day Health Care Centers, Multipurpose Senior Services Programs, Linkages Programs, Senior Companion Programs, Alzheimer Day Care Resource Centers, Family Caregiver Support Programs, and Senior Community Services Employment Programs.

9) Additional Comments (optional)

AAA staff and their subcontractor providers are essential stakeholders in the local MHSA decision making process. The community-based aging and long term care system provides opportunities for leveraging resources: ” to extend MHSA programs and funding by leveraging resources and funding sources, including ones not traditionally identified as mental health, to significantly increase the total resources brought to bear to address mental health issues." (*MHSOAC Mental Health Services Act Prevention and Early Intervention: County and State Policy Direction,” Adopted by the MHSOAC Jan 26, 2007; Amended by MHSOAC, September 11, 2007.)*

HOME DELIVERED MEALS PREVENTION AND EARLY INTERVENTION PROGRAM SERVICE COMPONENTS AND STAFF RESPONSIBILITIES							
STAFF AND VOLUNTEERS	**EDUCATION AND TRAINING**	**DEPRESSION SCREENING**	**ASSESSMENT**	**BRIEF INTERVENTION**	**REFERRAL**	**CARE COORDINATION**	**FOLLOW-UP**
Volunteer Drivers	Trained by the mental health clinician to recognize signs and symptoms of depression, suicide risk, co-occurring disorders, abuse/ neglect, change in mental, physical status and home environment. Trained to use "Daily Status Checklist" monitoring tool.	Picks up Depression Screening Form in a confidential sealed envelope from client/caregiver within two weeks of starting home delivered meals service.	Trained to provide "Daily Status Checks" including monitoring mental and emotional status, any change in behavior or home environment.		Informs mental health clinician of any change in client/caregiver mental, emotional, physical, home environment status.		Monitors how the client is doing on a daily basis. Provides daily contact to reduce social isolation and loneliness.
Registered Dietician/ Program Manager	Trained by the mental health clinician to recognize signs and symptoms of depression, suicide risk, co-occurring disorders, abuse/neglect, and any change in mental/physical state or home environment.						

STAFF AND VOLUNTEERS	EDUCATION AND TRAINING	DEPRESSION SCREENING	ASSESSMENT	BRIEF INTERVENTION	REFERRAL	CARE COORDINATION	FOLLOW-UP
Eligibility Worker	Trained by the mental health clinician to recognize signs and symptoms of depression, suicide risk, co-occurring disorders, abuse/neglect, and any change in mental/physical state or home environment	Provides mental health and depression information with client/caregivers during initial eligibility assessment. Provides/reviews copy of depression screening form requesting completion within two weeks of starting home delivered meals.	Provides initial home delivered meals eligibility and nutritional assessment and reassessment. Assesses need for community support services. Assesses home environment.				
Licensed Geriatric Mental Health Clinician	Provides training to staff and drivers regarding PEI services, signs and symptoms of depression, suicide risk, co-occurring disorders, abuse/ neglect, change in mental, physical status and home environment. Provide training on cultural and ethnic diversity issues.	Reviews and interprets depression screening results. Meets with client and caregiver to discuss screening results and next steps.	Performs mental health assessment for clients and caregivers who score positively on depression screening.	Provides brief intervention counseling to clients who exhibit initial onset of depression: Problem Solving Treatment (PST) and Behavioral Activation Therapy.	Provides referral to mental health providers and/or primary health care provider if client requires more than PST or Behavioral Activation Therapy to address depression. Refer to other community resources such as aging services, alcohol and drug.	Coordinates linkage and treatment services for clients and caregivers who are referred for depression treatment or other community resources.	Provides ongoing follow-up to determine what resources are being utilized and what is the response to treatment. Provide follow-up depression screening to monitor response to treatment.

STAFF AND VOLUNTEERS	EDUCATION AND TRAINING	DEPRESSION SCREENING	ASSESSMENT	BRIEF INTERVENTION	REFERRAL	CARE COORDINATION	FOLLOW-UP
Senior Peer Counselors	Receives training and supervision from the mental health clinician (or the local senior peer counseling program) in working with older adults with mental health needs.						Provides supportive counseling to clients and caregivers who could benefit from volunteer counselor, to reduce social isolation and loneliness, and to promote socialization and emotional connection.
Peer Support Counselor	Receives training and supervision from the mental health clinician regarding working with home delivered meals clients and caregivers who have mental health needs.						Provides peer support services to clients to promote recovery and resilience based on personal experience with mental illness and recovery. Promotes socialization and reduces social isolation and loneliness.